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Bibliography #15

Outcomes for Primary Health Care Programs Serving People Who Are Homeless

January 2002

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2001

National Gains Center for People With Co-Occurring Disorders in the Justice System. **Integrated Services Reduce Recidivism Among Homeless Adults With Serious Mental Illness in California.** Delmar, NY: National Gains Center for People With Co-Occurring Disorders in the Justice System, 2001.

The recent report, Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness, submitted to the California state legislature establishes the impressive results of California's broadened support of its Community Mental Health Treatment Program, known in shorthand as AB 2034, that serves adults with severe mental illness who are homeless or at risk of homelessness or incarceration. It is summarized here in fact sheet form to make the results more easily accessible to a wider audience.

Rosenheck R, Morrissey J, Lam J, Calloway M, Stolar M, Johnsen M, Randolph F, Blasinsky M, Goldman H. **Service delivery and community: social capital, service systems integration, and outcomes among homeless persons with severe mental illness**. Health Serv Res, 36(4):691-710, August 2001.

OBJECTIVES: To evaluate the influence of features of community social environment and service system integration on service use, housing, and clinical outcomes among homeless people with serious mental illness. SETTING: A one-year observational outcome study was conducted of homeless people with serious mental illness at 18 sites. DATA SOURCES: Measures of community social environment (e.g., social capital) were based on local surveys and voting records. Housing affordability was assessed with housing survey data. Service system integration was assessed through interviews with key informants at each site to document interorganizational transactions. Standardized clinical measures were used to assess clinical and housing outcomes in face-to-face interviews. RESEARCH DESIGN: Structural equation modeling was used to determine the relationship between (1) characteristics of the social environment (social capital, housing affordability); (2) the level of integration of the service system for persons who are homeless in each community; (3) access to and use of services by individual clients; and (4) successful exit from homelessness or clinical improvement. PRINCIPAL FINDINGS: Social capital was associated with greater service systems integration, which was associated in turn with greater access to assistance from a public housing agency and to a greater probability of exiting from homelessness at 12 months. Housing affordability also predicted exit from homelessness. Neither environmental factors nor systems integration predicted outcomes for psychiatric problems, substance abuse, employment, physical health, or income support. CONCLUSION: Community social capital and service system integration are related through a series of direct and indirect pathways with better housing outcomes but not with superior clinical outcomes for homeless people with mental illness. Implications for designing improved service systems are discussed.

2000

Kiel JM. **Understanding and managing integrated delivery networks.** Health Care Manag, 18(4):41-7, June 2000.

This article presents a guide for "managing managed care." To be successful in the transition from the fee-for-service payment system to capitation, the manager first needs to understand the five roles (the players) and their integration. The five roles are the employer, the insurer, the primary care physician, the specialist

physician, and the hospital. Once a health care manager understands the dynamics between these roles and their involvement in operations such as finance, contracting, and utilization review, managed care can then be managed. This guide is also beneficial to managers for understanding how to work with someone in another role.

1999

Clinicians' Network. **Integrated, interdisciplinary models of care**. Healing Hands 3(5), August 1999.

This newsletter focuses on an integrated, interdisciplinary model of health care - what it is and how it works. It stressed the importance of comprehensive and coordinated services and offers guidance on making interdisciplinary teams work. AVAILABLE FROM: Clinicians' Network, PO Box 68019, Nashville, TN 37206

HomeBase. **Turning homelessness around: restructure mainstream systems; integrate homeless specific responses**. San Francisco, CA: HomeBase, 1999.

This is an overview of successful strategies used by the Bay Area Regional Initiative (BARI) to Turn Homelessness Around. BARI offers five successful strategies to assist people in leaving homelessness: increase incomes; access stable, permanent housing; improve delivery of support services; build community; and integrate homeless and mainstream services. The report describes each strategy and offers examples of successful programs. AVAILABLE FROM: HomeBase, 870 Market St., Ste 1228, San Francisco, CA 94102.

United States General Accounting Office. **Homelessness: state and local efforts to integrate and evaluate homeless assistance programs**. Washington, DC: U.S. General Accounting Office, 1999.

To provide assistance to homeless people and to meet their complex needs, states and localities are linking and integrating homeless assistance programs with mainstream social service systems. Some are also beginning to use outcome measures to better manage their programs and to help ensure that their limited resources are being targeted to the most successful programs. This report describes some notable examples of efforts by states and localities to: link and integrate their homeless assistance programs with mainstream systems and measure and evaluate outcomes for their homeless assistance programs. AVAILABLE FROM: U.S. General Accounting Office, PO Box 37050, Washington, DC 20013. (202) 512-6000. (COST: FREE) (GAO/RCED-99-178)

1998

Anderson RJ, Pickens S, Boumbulian PJ. **Toward a new urban health model: moving beyond the safety net to save the safety net--resetting priorities for healthy communities.** J Urban Health, 75(2):367-78, June 1998.

Parkland Health and Hospital System has been successful by every measure of comparison among its peer institutions, yet it recognizes the imperative of adapting to changes in the regulatory, legislative, and market environments. Given its mandate and a desire to preserve its multiple missions and its partnerships with a highly rated medical school, the playing field for achieving robust survival is very uneven. This article describes the evolution of one of the best "sick care systems" in the United States into an integrated, excellent health care

system for the 21st century. The problems faced by the safety net in many urban areas of this country are similar. Many problems are structural in nature and will, therefore, require structural solutions at the local, state, and national levels. Parkland will continue and will be needed for many years as the tertiary and quaternary center of a comprehensive service network made up also of a series of outreach Community Oriented Primary Care clinics and special populations projects. In addition, we hope to help create a community-oriented managed-care plan that encompasses the desire to work with both denominator and numerator populations in a real partnership with many other stakeholders.

Bebout RR. **The Community Connections Housing Program: preventing homelessness by integrating housing and supports.** Under review at Alcohol Treatment Quarterly, 1998.

This paper describes the key features of a comprehensive housing program serving formerly homeless and at-risk adults with serious and persistent mental illness. The program combines intensive case management, integrated dual diagnosis treatment, and other clinical services with a range of housing options which are operated under the auspices of a single agency. For individuals with co-occurring substance use disorder, housing responses are guided by a four stage model of treatment and recovery. The authors offer a rationale for the continuum approach's relevance for high risk populations, especially those in poor urban settings where safety and harm reduction are a high priority.

Brindis C; Hughes D; Halfon N; Newacheck P. **The use of formative evaluation to assess integrated services for children: The Robert Wood Johnson Foundation Child Health Initiative.** Evaluation & the Health Professions, 21(1): 66-90, March 1998.

This article describes the use of formative evaluation in assessing the feasibility of implementing a new service integration effort. The Child Health Initiative, a nine-state, national demonstration project funded in 1991 by the Robert Wood Johnson Foundation, sought to implement systemic change through the creation of new mechanisms for spending service dollars more flexibly at the local site. The Child Health Initiative called for developing local child health-monitoring systems, a care coordination mechanism, and a program for decategorizing the myriad restrictive categorical public programs serving children. Most demonstration communities experienced some degree of success in achieving the first two components, but none was able to implement decategorization during the three- to five-year funding period. Key lessons for evaluators include the need for: (1) a flexible evaluation design that can sequentially adapt to changes in program implementation; (2) repeated longitudinal data collection measures to document changes over time; (3) avoidance of a premature focus on program outcomes; and (4) methods to establish attribution of outcomes.

Cocozza JJ; Steadman HJ; Dennis DL. **Implementing systems integration strategies: lessons from the ACCESS program.** In press, Administration and Policy in Mental Health, 1998.

The Access to Community Care and Effective Services and Supports (ACCESS) was established to identify promising approaches to systems integration and to evaluate their effectiveness in providing services to the homeless persons with mental illness. This paper addresses the first of these goals and provides findings from the evaluation of the ACCESS program on the approaches selected and employed by the participating program sites in their effort to improve the integration of the variety of service systems relevant to the target population.

Dennis DL; Cocozza JJ; Steadman HJ. **What do we know about systems integration and homelessness?** Washington, DC: Presented at the National Symposium of Homelessness Research, October 29-30, 1998.

This paper examines the role of systems integration in addressing homelessness. The goals of integration are to

improve access to comprehensive services and continuity of care; to reduce service duplication, inefficiency, and costs; and to establish greater accountability. The authors examine the definitions and differences between systems and services integration, initiatives designed to encourage the use of systems integration in programs to assist the homeless, and factors in making systems integration work.

Drake RE; McFadden CM; Mueser KT; McHugo GJ; Bond GR. **Review of integrated mental health and substance abuse treatment for patients with dual disorders.** Schizophrenia Bulletin 24(4): 589-608, 1998.

This article reviews 36 research studies on the effectiveness of integrated treatments for dually diagnosed patients. Studies of adding dual-disorders groups to traditional services, studies of intensive integrated treatments in controlled settings, and studies of demonstration projects have yielded disappointing results. However, 10 recent studies of comprehensive, integrated outpatient treatment programs provide encouraging evidence of the programs' potential to engage dually-diagnosed patients in services and to help them reduce substance abuse and attain remission. Outcome related to hospital use, psychiatric symptoms, and other domains remain less consistent. Several program features appear to be associated with effectiveness: assertive outreach, case management, and a longitudinal, stage-wise, motivational approach to substance abuse treatment.

Earnest MP, Grimm SM, Malmgren MA, Martin BA, Meehan M, Potter MB, Steele AW, Zocholl JR . **Quality improvement in an integrated urban healthcare system: a necessary journey.** Cin Perform Qual Health Care 1998 Oct-Dec;6(4):193-200

Public hospitals and clinics in the U.S. provide health care for the needs of large numbers of people who are medically indigent, homeless, chronically mentally ill, and suffer medical and social disorders associated with poverty. These "safety-net" healthcare providers traditionally struggle with barriers to providing high-quality, patient-sensitive care, including decaying physical facilities, burdensome bureaucracies, underfunded capital equipment and construction programs, and complex, politically driven budgets and governance. However, these same institutions now must compete for their own Medicaid and Medicare clientele because the private sector is marketing to those patients. They also must continue to provide increasing services to growing numbers of uninsured patients. To accomplish this, institutions must reinvent themselves as patient-focused, high-quality, cost-effective healthcare providers. The Denver Health system is the public safety-net provider for the city and county of Denver. This large public institution has instituted a multifaceted performance- improvement program. The program includes training employees for patient-focused service, implementing continuous quality-improvement practices, instituting clinical pathways, revising the preexisting ambulatory quality-management program, reengineering key aspects of ambulatory clinic services, and redesigning the hospital-based patient-care services. Major successes have been achieved in some initiatives, but not in all.

James DM. **An integrated model for inner-city health-care delivery: The Deaconess Center.** J Natl Med Assoc, 90(1):35-9, January 1998.

Under the auspices of the Buffalo General Hospital and the faculty of medicine of the State University of New York at Buffalo a comprehensive delivery system for primary care has been established in a local inner-city neighborhood. At the Deaconess Family Medicine Center, located within an inner-city location of Buffalo, New York, several divisions have been integrated to provide comprehensive patient-oriented primary care. These divisions include a primary care clinic, an urgent care clinic, a substance abuse clinic, and a community pediatrics clinic. Professional services are provided by attending physicians and residents. The horizontal integration of these four divisions is in turn vertically integrated with the tertiary care teaching hospital inpatient and obstetrical services, providing a continuum of patient care. The horizontal integration serves as an entry point for patients to enter the hospital's health-care system, while the vertical integration capability serves to capture any specialized referrals or inpatient needs. This article discusses the structure of the center, with special reference to service

integration, service delivery, and patient capture; medical education; and the place of integrated units in the strategic plan of a tertiary care hospital.

Ogborne, AC; Braun K; Rush BR. **Developing an integrated information system for specialized addiction treatment agencies.** The Journal of Behavioral Health Services and Research 25(1): 100-107, 1998.

This article outlines the development of an integrated information system for specialized alcohol and drug treatment agencies in Ontario, Canada. The system is being developed following a strategic planning process involving provincial funding ministries and coalitions of service providers. An overview of the system's development is provided and the implementation of one subcomponent, a client tracking system, is described. The authors conclude that once the cost and outcome components are in place, the system will show which services are most cost effective for particular groups of clients and how resources could be redistributed to maximize the efficiency of the overall system.

Ridgely MS; Lambert D; Goodman A; Chichester CS; Ralph R. **Interagency collaboration in services for people with co-occurring mental illness and substance use disorder.** Psychiatric Services 49(2): 236-238, 1998.

The authors describe a program in Maine designed to develop a collaborative, or communities of providers, who work together to offer coordinated mental health and substance abuse treatment and support. Surveys of provider agencies in one collaborative conducted one year and two years after the collaborative was established showed an increase in interagency referrals, joint assessments of clients, and jointly sponsored training and client services. The authors conclude that developing a collaborative of providers to serve clients with co-occurring disorders offers a cost-effective approach to maximizing current resources and improving the local delivery of services.

Rosenheck R, Morrissey J, Lam J, Calloway M, Johnsen M, Goldman H, Randolph F, Blasinsky M, Fontana A, Calsyn R, Teague G. **Service system integration, access to services, and housing outcomes in a program for homeless persons with severe mental illness.** Am J Public Health, 88(11):1610-5, November 1998.

OBJECTIVES: This study evaluated the hypothesis that greater integration and coordination between agencies within service systems is associated with greater accessibility of services and improved client housing outcomes. METHODS: As part of the Access to Community Care and Effective Services and Supports program, data were obtained on baseline client characteristics, service use, and 3-month and 12-month outcomes from 1832 clients seen at 18 sites during the first year of program operation. Data on interorganizational relationships were obtained from structured interviews with key informants from relevant organizations in each community (n=32-82 at each site). RESULTS: Complete follow-up data were obtained from 1340 clients (73%). After control for baseline characteristics, service system integration was associated with superior housing outcomes at 12 months, and this relationship was mediated through greater access to housing agencies. CONCLUSIONS: Service system integration is related to improved access to housing services and better housing outcomes among homeless people with mental illness.

Rowe M, Hoge MA, Fisk D. **Services for mentally ill homeless persons: street-level integration.** Am J Orthopsychiatry, 68(3):490-6, July 1998.

The key elements of a systems integration approach to delivery of human services are reviewed in terms of their application to services for mentally ill homeless persons. The example of a mental health outreach project illustrates the service- and systems-integrating influences of clinical case management with this population, and

the ability of a "bottom-up" street-level approach to improve coordination and service accessibility for clients in general is discussed.

Woods ER, Samples CL, Melchiono MW, Keenan PM, Fox DJ, Chase LH, Tierney S, Price VA, Paradise JE, O'Brien RF, Mansfield CJ, Brooke RA, Allen D, Goodman E. **Boston HAPPENS Program: a model of health care for HIV-positive, homeless, and at-risk youth. Human immunodeficiency virus (HIV) Adolescent Provider and Peer Education Network for Services.** J Adolesc Health 1998 Aug;23(2 Suppl):37-48

The Boston HAPPENS [HIV Adolescent Provider and Peer Education Network for Services] Program is a project supported by Special Projects of National Significance (SPNS) Program, HIV/AIDS Bureau, Health Resources and Services Administration, which provides a network of care for homeless, at-risk, and HIV-positive youth (ages 12-24 years), involving eight agencies. The program has provided services to 1,301 youth, including 46 who are HIV-positive. Boston HAPPENS provides a citywide network of culturally and developmentally appropriate adolescent-specific care, including: (1) outreach and risk-reduction counseling through professional and adult-supervised peer staff; (2) access to HIV counseling and testing support services; (3) life management counseling (mental health intake and visits as part of health care and at times of crisis); (4) health status screening and services needs assessment; (5) client-focused, comprehensive, multidisciplinary care and support; (6) follow-up and outreach to ensure continuing care; and (7) integrated care and communication among providers in the Boston area. This innovative network of youth-specific care offers a continuum from street outreach to referral and HIV specialty care that crosses institutional barriers.

1997

Busen NH; Beech B. **A collaborative model for community-based health care screening of homeless adolescents**. J Prof Nurs, 13(5):316-324 , September 1997.

Because of their survival life-style, homeless youth are at extremely high risk for contracting life-threatening and debilitating diseases, such as acquired immunodeficiency syndrome and hepatitis B, and for engaging in chronic substance abuse; yet health services are often limited and not easily accessed. This article describes an innovative health-screening project for 150 homeless youth between the ages of 11 and 23 years in an urban metroplex. The Homeless Youth Services Project was the initial phase of a multiphase project to investigate the social and health services available to homeless youth. The study project was a collaborative effort between several community agencies that shared the multiple goals of identifying the homeless adolescent population, documenting the rate of human immunodeficiency virus (HIV) seroprevalence and level of risk, and identifying community services and resources. Results of the screening project included the psychosocial and physical risks associated with homeless adolescents as well as the laboratory results of blood and urine screens. Consistent with the literature, the study population had a history of runaway behavior; physical, sexual, and substance abuse; and high rates of HIV seroprevalence and hepatitis B. Implications for advanced practice nurses working with homeless youth are also addressed.

Casey M. **Integrated networks and health care provider cooperatives: new models for rural health care delivery and financing.** Health Care Manage Rev 22(2): 41-48, 1997.

Minnesota's 1994 health care reform legislation authorized the establishment of community integrated service networks (CISNs) and health care provider cooperatives, which were envisioned as new health care delivery models that could be successfully implemented in rural areas of the state. Four CISNs are licensed, and three organizations are incorporated as health care provider cooperatives. Many of the policy issues Minnesota has

faced regarding the development of CISNs and health care provider cooperatives in rural areas are similar to those raised by current Medicare reform proposals.

Drake RE; Yovetich NA; Bebout RR; Harris M; McHugo GJ. **Integrated Treatment for Dually Diagnosed Homeless Adults.** Journal of Nervous Mental Disorders, 185(5): 298-305, 1997

This study examined the effects of integrating mental health, substance abuse, and housing interventions for homeless persons with co-occurring severe mental illness and substance use disorder. Integrated treatment was compared with standard treatment for 217 homeless, dually diagnosed adults over 18 months. The integrated treatment group had fewer institutional days and more days in stable housing, made more progress toward recovery from substance abuse and showed greater improvement of alcohol use disorders than the standard treatment group. Abuse of drugs other than alcohol (primarily cocaine) improved similarly for both groups.

Fosberg L; Locke G; Peck L; Finkel M. **National evaluation of the Shelter Plus Care Program.** Washington, DC: U.S. Department of Housing and Urban Development, 1997.

This report presents the results of the national evaluation of the United States Department of Housing and Urban Development's (HUD) Shelter Plus Care Program (S+C), based on the experience of FY 92 grantees in using FY 92 and, for some, FY 93 funding. The report gives an overview of S+C and describes program implementation, participant characteristics, supportive services, housing, and program outcomes. The report finds that S+C participants overall have made increases in their participation in services and in employment or volunteer work. A number of recommendations are made for S+C participants and for HUD policy.

Fuller S. **Regional health information systems: applying the IAIMS model.** J American Medical Informatics Assn. 4(2): S47-S51, March - April 1997.

In general, there is agreement that robust integrated information systems are the foundation for building successful regional health care delivery systems. Integrated Advanced Information Management System (IAIMS) institutions that, over the years, have developed strategies for creating cohesive institutional information systems and services are finding that IAIMS strategies work well in the even more complex regional environment. The key elements of IAIMS planning are described and lessons learned are discussed in the context of regional health information systems developed. The challenges of aligning the various information agencies and agenda in support of a regional health information system are complex; however, the potential rewards for health care in quality, efficacy, and cost savings are enormous.

Kizer KW, Fonseca ML, Long LM. **The veterans healthcare system: preparing for the twenty-first century.** Hosp Health Serv Adm, 42(3):283-98, Fall 1997.

Since its establishment in 1946, the veterans healthcare system has greatly expanded in both size and responsibility. It is now the largest integrated healthcare system in the United States, the nation's largest provider of graduate medical and other health professionals training, and one of the largest research enterprises in America. It is also the nation's largest provider of services to homeless persons, an essential provider in the public healthcare safety net, and an increasingly important element in the federal response to disasters and national emergencies. Patterned after what was considered the best in American healthcare, for most of the past 50 years the Department of Veterans Affairs (VA) healthcare has focused primarily on acute inpatient care, high technology, and medical specialization. Now, in response to societal and industrywide forces, the Veterans Health Administration (VHA) is reengineering the veterans healthcare system, changing the operational and management structure from individual hospitals to 22 integrated service networks and transitioning the system to one that is grounded in ambulatory and

primary care. This article briefly describes the history and functions of the veterans healthcare system, its service population, and key aspects of its restructuring.

Mitchell J. **Basic principles of information technology organizations in health care institutions**. J American Medical Informatics Assn 4(2): S31-S35, March-April 1997.

This paper looks at the basic principles of information technology (IT) organization within health science centers and considers the placement of the leader of the IT effort within the health sciences administrative structure and the organization of the IT unit. A case study of the University of Missouri - Columbia Health Sciences Center demonstrated how a role-based organizational model for IT support can be effective for determining the boundary between centralized and decentralized organizations. The conclusions are that the IT leader needs to be positioned with other institutional leaders who are making strategic decisions, and that the internal IT structure needs to be a role-based hybrid of centralized and decentralized units. The IT leader needs to understand the mission of the organization and actively use change-management techniques.

Morrissey J, Calloway M, Johnsen M, Ullman M. **Service system performance and integration: A baseline profile of the ACCESS demonstration sites. Access to community care and effective services and supports**. Psychiatr Serv, 48(3):374-380, March 1997.

OBJECTIVE: Networks of agencies at the 18 demonstration sites in the Access to Community Care and Effective Services and Supports (ACCESS) program for homeless persons with serious mental illness were surveyed to profile baseline levels of systems performance and integration as part of a longitudinal evaluation of systems change and client outcomes. METHODS: Interviews were conducted with a representative from each of 875 agencies in the 18 service networks. Information was obtained about the perceived performance of the service system and the extent of systems integration as measured by client referrals, funds exchanges, and information sharing between agencies. Measures consisted of two multi-item scales assessing the accessibility and coordination of services for the target population in each community and four indexes of interagency relationships. RESULTS: Services at baseline for homeless mentally ill persons at the program sites were rated as relatively inaccessible, and the coordination of services between agencies was rated as even more problematic. Interagency ties were largely based on client referrals and information exchanges, with very few instances of funding transfers in the form of contracts or grants. Baseline agencies that had received an ACCESS grant were better connected to their local service network than were other agencies. CONCLUSIONS: Consistent with the premise of the ACCESS demonstration, services for persons who are homeless and mentally ill in urban America are fragmented and not very accessible. The longitudinal design of the evaluation will allow for an assessment of efforts to improve services and systems integration and of the effects of these improvements on client outcomes.

Provan KG. **Services integration for vulnerable populations: lessons from community mental health.** Family and Community Health 19(4):19-30, 1997.

This article examines the presumed benefits and problems concerning integration of health and human services for vulnerable clients. Findings from a study of services integration in community mental health are summarized, and conclusions are drawn about whether integration is beneficial for client outcomes. In contrast to the generally held wisdom that "more integration is better," results indicate that high integration among provider agencies does not result in more favorable outcomes, but that services integration is most effective when coordinated through a single core provider. Conclusions for structuring service systems for vulnerable clients are discussed and policy recommendations are made.

Randolph F; Blasinky M; Leginski W; Parker LB; Goldman HH. **Creating integrated service systems for homeless persons with mental illness: the ACCESS Program**. Psychiatric Services 48(3):369-373, 1997.

The Access to Community Care and Effective Services and Supports (ACCESS) demonstration program was initiated in 1993 by the U.S. Department of Health and Human Services as part of a national agenda to end homelessness among persons with serious mental illness. Demonstration projects have been established in nine states to develop integrated systems of care. This article provides an overview of the ACCESS program and presents definitions of services integration and systems integration. Evaluating the effectiveness of integration strategies is a critical aspect of the program. The authors describe the evaluation design and the integration strategies being evaluated and summarize findings from a formative evaluation of the project's first two years. The evaluation revealed several problems that were addressed by providing technical assistance. States were helped to articulate a broader mission of addressing system-level barriers, develop an expanded plan, strengthen the authority of interagency councils, involve leaders at the state and agency levels, and develop joint funding strategies.

Richmond Homeless Services Task Force **Recommendations for the development of a nonprofit homeless services coordination organization for metropolitan Richmond.** Richmond, VA: Richmond Homeless Services Task Force, 1997.

This document provides information about an initiative to respond to the problem of homelessness in the metropolitan Richmond area. The Richmond Homeless Services Task Force outlines its recommendations and basic program design for creating a homeless services coordination organization. The report features several sections including a business plan; recommendations for development; mission, values and guiding principles; and recommendations for establishing a board of directors. The Task Force states that a coordination organization would move systems integration forward and could develop the following enhancements: a data base and computer network, a central intake system, a primary case management system, and a homeless prevention program.

Tierney W; Overhage M; McDonald C. **Demonstrating the effects of IAIMS on health care quality and cost.** JAIMIA 4(2): S41-S46. March-April 1997.

The importance of demonstrating the effect of integrating electronic medical records into clinical practice, and methods for conducting the studies necessary to do so, are presented as a model that may be applicable to other aspects of the Integrated Advanced Information Management System (IAIMS). Integrated electronic medical record (EMR) systems offer the prospect of both improving the quality of health care by reducing variation in processes and outcomes and lowering its costs. Because such systems are expensive and require time-consuming re-engineering of health care delivery, demonstrating effectiveness should be part of study design that the local clinical environment can support. Results of useful studies include both processes and outcomes of care, the latter including both objective and subjective measures. Comprehensive testing of EMR innovations requires a multi-specialty team of investigators, adequate funding, and a commitment of both informaticists and clinicians. Demonstrating the beneficial effects of integrated EMR systems will facilitate their incorporation into everyday clinical care.

Ulmer C; Lewis-Idema D; Falik M; Raggio TP; Stoessel P; Coughlin T; Butterworth D; Tillman J. **Categorical funding to seamless systems of care: the challenge for community-based primary care providers**. J.Case Manag, 6(3):96-103, 1997.

Integrating categorical funding to design "seamless systems of care" for individual patients is a challenge faced by many local community-based providers. Providers may choose to develop separate site-specific categorical programs for patients with human immunodeficiency virus (HIV) [e.g., specialized treatment site or a homeless clinic] or integrate these programs with their general primary care population. Regardless of program location, providers have developed patterns for finding the most appropriate medical home for a patient with multiple categorical risks. Medical records reviews and patient interviews indicate the importance of case managers in

service coordination, although clinical issues appear more readily coordinated than situational ones. Provider dependence solely on case managers for service coordination, across sites and programs may become problematic in the era of managed care without a supportive information system that tracks client use and a records system that integrates clinical and social service notes. Local providers have encountered difficulties in exchanging essential medical information, even within a single agency, under state statutes regarding confidentiality of HIV test results.

1996

Brauzer B; Lefley HP; Steinbook R. **A module for training residents in public mental health systems and community resources.** Psychiatr Serv 47:192-4, February 1996.

The authors describe a six-month training module in public psychiatry developed in 1991 at the University of Miami Medical School. The module is centered on weekly intensive site visits to a range of community and advocacy programs, including the state hospital, services targeted to different groups at various community mental health centers, substance abuse treatment programs, forensic sites, rehabilitation centers, and family and consumer groups. Preliminary evaluation results indicate that residents gain a better understanding of community services and of system linkages and barriers and appear to develop a more positive prognostic attitude. They also gain a clearer picture of the many roles of community psychiatrists.

Chandler D; Meisel J; Hu TW; McGowen M; Madison K. **Client Outcomes in a Three-year Controlled Study of an Integrated Service Agency Model.** Psychiatric Services 47: 1337-1343, December 1996.

OBJECTIVE: In a three-year controlled study, two California integrated service agency demonstration programs that combined structural and program reforms were tested to see if they produced improved outcomes for a cross-section of clients with severe and persistent mental illness. METHODS: Clients at an urban site and a rural site were randomly assigned to an integrated service agency program or to a comparison group who received the usual services. Data on client outcomes, were drawn from databases and client and family interviews. RESULTS: Compared with the comparison groups, clients served by the integrated service agencies had less hospital care, greater workforce participation, fewer group and institutional housing arrangements, less use of conservatorship, greater social support, more leisure activity, less family burden, and greater client and family satisfaction. Clients in the urban demonstration program, but not those in the rural program, did better than the comparison group on measures of financial stability, personal well-being, and friendship. At the urban site, 2.6% of clients participated in the work force during the three-year study period, compared with 14.6% of the clients in the comparison group. No differences were found at either site in rates of arrest and conviction and in self-reported ratings of self-esteem, symptoms, medication compliance, homelessness, and criminal victimization. The capitated costs for demonstration clients were much higher than the costs for services used by comparison clients. CONCLUSIONS: Three-year outcomes for a cross-section of clients with severe mental illness in the integrated service agencies were broadly favorable, but costs of services for those clients were high relative to costs for clients receiving the current standard of care.

Clark DL. **Negotiating innovative relationships with pharmaceutical companies: integrated health systems' perspective**. Am J Health Syst Pharm 53:S39-41, Feb. 15, 1996.

Corporation for Supportive Housing. **Health, housing and integrated services network managed care**

demonstration project. Oakland, CA: Corporation for Supportive Housing, 1996.

Corporation for Supportive Housing is working in partnership with the San Francisco Department of Public Health, the Alameda County Health Services Agency, and non-profit housing and service providers to create a new, non-profit, integrated service system. This system will provide health care, mental health, substance abuse treatment, social and vocational services and employment opportunities in conjunction with service-enriched housing for approximately 750 single adults who are homeless or "at risk" and have HIV/AIDS, chronic mental illness, and/or substance abuse disorders. These services will allow homeless or "at risk" persons with disabilities to achieve more stable, independent living with better health status. It will also reduce their utilization of costly emergency and inpatient medical and psychiatric services, jails, and prisons. Service utilization, cost, and outcome data will be used to establish capitation rates or other risk-sharing agreements for ongoing managed care financing.

Ehrhart PM; Furlong B. **Integrating mental health into community health nursing**. Nurse Educ 21:33-6, May-June 1996.

Future nursing graduates will face a challenge as they seek employment in a changing health care system. A managed-care system using community-based sites is the trend of the future, with economy of care as the norm. The authors describe one model for educating students to meet community mental health challenges. The chronically mentally ill have traditionally been underserved in the community, resulting in frequent and costly readmissions to psychiatric hospitals. Appropriately prepared graduates can successfully manage the care of these clients economically in the community. The integration of community mental health into the community health course group meets that challenge.

Essock SM. **Hope and possibility: integrated treatment of substance abuse and mental illness for homeless people with dual diagnosis**. Hartford, CT: Connecticut Department of Mental Health and Addiction Services, 1996.

This manual discusses the most recent approaches in the treatment of people who are homeless and have both substance abuse and serious mental disorders. The author explains that integrating the treatment of both types of disorders for delivery by assertive community treatment teams and other forms of intensive case management is a relatively new, and still developing, approach. This manual can be regarded as a document in progress, a framework which will be filled in gradually based on continuing experiences with dually diagnosed homeless people. Topics discussed include: conceptual framework logic model; history and setting of intervention; assertive community treatment (ACT) teams; the treatment process; logic model; engagement; persuasion; active treatment stage; relapse prevention; housing; and recommendations. AVAILABLE FROM: Connecticut Dept. of Mental Health and Addiction Services, 410 Capitol Ave., MS #14RSD, PO Box 34131, Hartford, CT 06134.

The Family Health Program of the Center for Mental Health. **Integrated Mental Health and Substance Abuse Services to At-Risk Families.** Psychiatric Services 47(10): 1112-1114, 1996.

This article describes in detail the winning program of the 1996 Gold Achievement Award presented by the American Psychiatric Association. The Family Health Program is a program which provides family-centered outpatient care that integrates mental health and substance abuse treatment, primary health care, and social support services for pregnant and postpartum women and their children and families.

Haq CL; Cleeland L; Gjerde CL; Goedken J; Poi E. **Student and faculty collaboration in a clinic for the medically underserved**. Fam Med, 28(8):570-574, September 1996.

BACKGROUND AND OBJECTIVES: Growing numbers of uninsured and underinsured individuals in the United

States have resulted in increased needs for health care for medically underserved populations. Educational strategies are needed that provide opportunities for students to develop the attitudes, knowledge, and skills necessary for providing quality health care for underserved patients. METHODS: Medical students, residents, and faculty of the University of Wisconsin-Madison Medical School worked together to establish extracurricular opportunities for first- and second-year students to participate in medical clinics serving the poor and homeless. The process for the development and operation of a volunteer clinic is described. RESULTS: In the last two years, 163 medical students, 27 residents, and 21 faculty have provided care to more than 1,000 patients. Patients, students, residents, and faculty reported high satisfaction with the experience. CONCLUSIONS: Medical students, residents, and faculty working in collaboration can provide increased access to care for the medically underserved. Engaging in community-oriented primary health care early in their medical education provided positive learning opportunities for medical students, especially those interested in generalist careers.

Hicks LL, Bopp KD. **Integrated pathways for managing rural health services**. Health Care Manage Rev, 21(1):65-72, 1996.

Rural providers must redefine their role in the changing health care system to include a more integrated approach to health care delivery. The rural provider must develop integrated pathways to coordinate all medical, behavior, and social services to ensure that appropriate services are available, locally or through linkages with other providers, for the population. The integrated pathway must manage care across the continuum of services and coordinate decisions occurring at the point of service.

Information systems ... health information networks could soon be linked [news]. Hospitals and Health Networks 70:12, 14, June 5, 1996.

Knapp MS. **Methodological issues in evaluating integrated services initiatives**. New Directions for Evaluation 69: 21-33, 1996.

This article explores the conceptualization and design of studies that evaluate integrated services initiatives. The article also examines special problems posed by integrated services for evaluators. The author states that integrated services are difficult to evaluate due to their complexity and flexibility, the nature of collaborative or integrated effort, and the convergence of different disciplines. The author suggests approaches for further evaluation of how these initiatives work and discusses what they are accomplishing.

Konrad EL. **A multidimensional framework for conceptualizing human services integration initiatives.** In Marquardt JM; Konrad EL (eds.), *Evaluating Initiatives to Integrate Human Services*. New Directions for Evaluation, 69:5-19. San Francisco, CA: Jossey-Bass, 1996.

Services integration (SI) initiatives are, complex approaches to service provision. They consist of multiple partners, operate along numerous dimensions and at various levels of intensity, and encompass a variety of components, structures, and designs. A brief history of services integration initiatives is provided and the following topics are discussed: levels of integration; collaboration; consolidation; dimensions of human services integration initiatives; target population; program policy and legislation; service delivery system or models; stakeholders; information systems and data management; and outcomes and accountability.

Lipson DJ; Naierman N. **Effects of health system changes on safety-net providers**. Health Aff (Millwood) 15:33-48, Summer 1996.

Growing competition in health care markets and Medicaid managed care, combined with cuts in government funds that subsidize care, challenge the viability of the safety net. In response to these pressures, "safety-net" providers in 15 communities are integrating vertically and horizontally, contracting with or forming managed care plans, and seeking to attract paying patients. Such strategies appear to be successful for community-based primary care clinics, but other providers -- including hospitals that cannot quickly develop primary care capacity, most local health departments, and providers that fail to attract Medicaid patients -- are more vulnerable to health system changes. While the safety net may be intact now, access to care among the uninsured is more at risk in communities without state programs or local taxes that subsidize such care.

Mayo K; White S; Oates SK; Franklin F. **Community collaboration: prevention and control of tuberculosis in a homeless shelter**. Public Health Nurs, 13(2):120-127, April 1996.

An urban shelter in Charleston, South Carolina developed and began a TB prevention and control plan that addressed the priorities recommended by the CDC. After an increase in TB in the shelter in 1992, the local health department, the homeless clinic nurse practitioners, and Medical University of South Carolina College of Nursing faculty and students collaborated with the shelter staff to provide initial mass screenings for contact investigation. They also developed and implemented new policies and procedures for an ongoing TB prevention and control program. The new policies required that guests obtain screening for TB within seven days of arrival at the shelter and every 6 months thereafter. Also, a public health nurse began providing directly observed therapy twice weekly at the shelter. Of the initial 22 persons who started TB preventive therapy in 1993, 17 (77%) completed therapy. The clinic nurse practitioners, nursing students, and public health nurses had important and defined roles in the mass-screening process, case identification and treatment, policy development and implementation, health education, and establishing methods of communication between the shelter, clinic, and health department. An ongoing health care community collaborative effort may successfully reduce TB in a homeless shelter population.

Miller E. **The evolution of integration: federal efforts from the 1960s to present day.** Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, August 1996.

This report is a synthesis of current and past literature regarding the evolution of integration as well as an inventory of some current federal integration efforts. The history and evolution of the concept of integration from the 1960s until present day is detailed including: the war on poverty; definition of integration; systems integration versus service integration; integration on a continuum; common themes in current federal integration efforts; and recommendations for the future of integration. In addition, 17 federal programs are reviewed including an analysis of their individual goals and structures.

Osher FC. **A vision for the future: toward a service system responsive to those with co-occurring addictive and mental disorders**. American Journal of Orthopsychiatry, 66(1):71-76, 1996.

The author explains that co-occurring addictive and mental disorders identified by providers, family members, administrators, and consumers are an issue creating frustration, high costs, and a profoundly negative impact on quality of life. With empirical research and clinical experience supporting the effectiveness of integrated approaches, the author considers the systemic division of addictive and mental health services, and contends that a change toward integrated systems of care is likely to benefit the mental health and addiction treatment needs of all people, not just those with co-occurring disorders.

Roberts RN; Wasik BH. **Evaluating the 1992 and 1993 community integrated service systems projects.** New Directions for Evaluation 69: 34-50, Spring 1996.

This article describes the federal evaluation of 41 Community Integrated Service Systems (CISS) projects,

focusing on issues in conducting a national, cross-site evaluation and the findings of the implementation study of the first two years of the initiative. An initial review of the individual project proposals and evaluation plans before development of the evaluation framework suggested the diversity of the 41 community-based efforts and the lack of common objectives and outcome measures. This finding, confirmed in a subsequent and more detailed analysis, required the development of an evaluation framework for describing the implementation of the overall effort. A framework was developed that relied less on individually collected project data and more on data that allowed for a cross-site analysis. The article concludes with lessons learned from the planning and execution of this evaluation plan relevant to national evaluation efforts.

U.S. Dept. of Housing and Urban Development. **The continuum of care: a report on the new federal policy to address homelessness.** New York: Barnard-Columbia Center for Urban Policy, Columbia University, 1996.

As part of its overall approach to community development, HUD's approach to breaking the cycle of homelessness, known as the Continuum of Care, has two key elements: (1) a coordinated community-based process of identifying needs and building a system to address those needs, and (2) a doubling of the HUD homelessness assistance budget to provide communities with resources to carry out these tasks. This report is an independent study of the implementation of the Continuum of Care. It provides an overview of the role of the Federal government in addressing homelessness and examines the changes that have taken place since the Clinton Administration first implemented this policy. The report is based on quantitative analysis of application data from funded programs in the period between 1990 and 1995, and detailed qualitative studies of Continuum of Care implementation efforts at nine selected sites across the country.

Vanderburg J. **Connections: a dyadic case management, integrated treatment program for homeless dually diagnosed individuals**. Thornton, CO: Connections Program, 1996.

This manual describes Arapahoe House's work with the target population, and presents the dyadic case management system in the context of the comprehensive continuum of services available to Connections clients. Actual intervention from outreach and client identification through long-term continuing care in the community is described, including the program's process, engagement, treatment, and relapse prevention activities. Lessons about strategies that other practitioners may find useful are outlined. AVAILABLE FROM: Arapahoe House, 8801 Lipan St., Thornton, CO. (303) 657-3700.

Wilkins, C. **Building a model managed care system for homeless adults with special needs: the health, housing, and integrated services network.** Current Issues in Public Health 2: 39-46, 1996.

The Health, Housing, and Integrated Services Network in California is an emerging partnership that includes two county public health departments and more than a dozen nonprofit organizations. It provides residential and outpatient mental health and substance abuse treatment services, health care, social and vocational services and affordable housing for people who are homeless, mentally ill, HIV-infected, or struggling with drug and alcohol problems. The organizations are collaborating to implement a dramatically different interdisciplinary program of services that integrates the delivery of primary health care, client-centered treatment for mental illness and substance abuse, and other health and support services, all linked to stable, affordable places to live. This article looks at the effectiveness of this model with a focus on the goals: (1) to provide integrated, flexible services through multidisciplinary teams; (2) to establish an interagency provider network; (3) to establish capitation rates and document cost effectiveness of interventions; and (4) to reduce categorical funding limitations. Major challenges and critical issues are also examined.

1995

Grusky, O. **The organization and effectiveness of community mental health systems.** Administration and Policy in Mental Health 22(4):361-388, 1995.

This article explores five hypotheses concerning why some county mental health systems are more effective than others: leadership succession, powerful agency, integrated system, service barriers, and resource dependency. These hypotheses were tested on several community mental service delivery systems in the northwest United States. Findings indicate that leadership succession, powerful agency, and level of service integration contribute to a successful service delivery system. However, service barriers and resource dependency made no significant contribution to the success or failure of the mental health systems under study.

The Enterprise Foundation. **Beyond housing: profiles of low-income, service-enriched housing for special needs populations.** Columbia, MD: The Enterprise Foundation, 1995.

This publication provides examples of both supportive housing programs that successfully demonstrate the integration of social services and housing, and property management programs that are sensitive to the needs of low-income people while demonstrating sound property management practices. States with service-enriched housing profiled include: California; Colorado; District of Columbia; Illinois; Kentucky; Maryland; New Jersey; New York; Ohio; Oregon; Pennsylvania; Rhode Island; Texas; Virginia; and Washington. AVAILABLE FROM: The Enterprise Foundation, 10227 Wincopin Circle, Suite 500, Columbia, MD 21044, (410) 964-1230. (COST: $20.00)

Galfalvy HC; Reddy SM; Niewiadomska-Bugaj M; Friedman S; Merkin B. **Evaluation of Community Care Network (CCN) system in a rural health care setting**. Proc Annu Symp Comput Appl Med Care 698-702, 1995.

Concurrent Engineering Research Center (CERC), under the sponsorship of NLM (National Library of Medicine) is in the process of developing a computerized patient record system for a clinical environment distributed in rural West Virginia. This realization of the CCN (Community Care Network), besides providing computer-based patient records accessible from a chain of clinics and one hospital, supports collaborative health care processes like referral and consulting. To evaluate the effectiveness of the system, a study was designed and is in the process of being executed. Three surveys were designed to provide subjective measures, and four experiments for collecting objective data. Data collection is taking place in several phases: baseline data are collected before the system is deployed; the process is repeated with minimal changes three, then six months later or as often as new versions of the system are installed. Results are then to be compared, using whenever possible matching techniques (i.e. the preliminary data collected on a provider will be matched with the data collected later on the same provider). Surveys are conducted through questionnaires distributed to providers and nurses and person-to-person interviews of the patients. The time spent on patient-chart related activities is measured by work-sampling, aided by a computer application running on a laptop PC. Information about missing patient record parts is collected by the providers, the frequency by which new features of the computerized system are used will be logged by the system itself and clinical outcome measures will be studied from the results of the clinics' own patient chart audits. Preliminary results of the surveys and plans for the immediate and distant future are discussed at the end of the paper.

Hutchison RR; Quartaro EG. **High-risk vulnerable populations and volunteers: a model of education and**

service collaboration. J Community Health Nurs, 12(2):111-119 , 1995.

Extending our earlier work (Hutchison & Quartaro, 1993) describing a training program for volunteers caring for high-risk vulnerable populations, we identify and explicate factors contributing to the successful collaboration of education and service organizations. Addressing the management of linkages essential to
mutual goal setting and shared responsibility for planning, implementation, and evaluation of patient/client outcomes, each factor is discussed with specific reference to improving caregiving to persons with AIDS and their families through well-trained volunteer services. The model has been applied to training for service to homeless persons and to the frail elderly and may be more broadly applicable to other high-risk vulnerable populations.

Lundberg MD. **Integrated service networks and Federally Qualified Health Centers**. Bethesda, MD: Bureau of Primary Health Care, 1995.

Involvement in Integrated Services Networks (ISN) is one of the new strategies being adopted by Federally Qualified Health Centers (FQHC) to assure they can continue to serve their patients under managed care arrangements. This document captures sixteen ISNs across the country in which FQHCs play a dominant role, providing a "snapshot" of key organizational features. Information includes the following: (1) ISN organizational structures; (2) legal arrangements; (3) financial risk arrangements; (4) capitalization; (5) membership; (6) service area; and (7) contact persons for each ISN.

Randolph FL. **Improving service systems through systems integration: the ACCESS program.** American Rehabilitation 21: 36-38, 1995.

This article describes the ACCESS (Access to Community Care and Effective Services and Supports) Program, which was initiated by the Center For Mental Health Services (CMHS) in 1993 in response to recommendations from the Federal Task Force on Homelessness and Severe Mental Illness. In September of 1993, nine states were awarded approximately $17 million in cooperative agreement grants for 18 communities to test systems reform strategies that encourage cooperation among different levels of government and voluntary organizations to eliminate service fragmentation and ultimately achieve integration of service systems for homeless persons with serious mental illnesses, particularly those with co-occurring alcohol or other substance use disorders. The states and localities receiving funds are: Bridgeport and New Haven, CT; two communities in Chicago, IL.; Sedgwick and Shawnee counties in Kansas; St. Louis and Kansas City, MO.; Mecklenburg and Wake counties, NC; two communities in Philadelphia, PA.; Austin and Fort Worth, TX; Richmond and Hampton/Newport News, VA.; and two communities in Seattle, WA.

Sevell RD. **An integrated delivery systems review: common problems to be addressed**. Health Care Law Newsletter 10(1): 3-8, January 1995.

The most critical element in developing a successful integrated delivery system (IDS) is identifying the needs and goals of the parties within the context of the realities of their local health care market. It is therefore unwise to select the structure of a proposed IDS until this process has been completed. An honest goals assessment might result in the immediate formation of a PHO, MSO, medical foundation or other formal IDS, or might alternatively point in the direction of something much less structured, such as a joint marketing contractual arrangement (sometimes called a PHA), which can be relatively inexpensive to implement and can provide a fairly immediate response to quickly changing market conditions. Some organizations might even decide to use a number of different IDS vehicles in order to offer physicians a menu of affiliation options. The legal issues that arise when forming an IDS can almost always be dealt with in a reasonable manner. The real key to success is entering into integration discussions with an open mind, rather than a preconceived commitment to a particular integration.

Yessian MR. **Learning from experience: integrating human services.** Public Welfare 34-42 Summer 1995.

The focus of this article is the opportunity for states to pursue human services integration (SI). The author reflects on attempts within the past two decades made by federal, state, and local governments; community agencies and coalitions; and private foundations, to engage in service integration activities. Lessons learned from these attempts are identified and discussed in relation to the current situation.

1994

Asmussen SM; Romano J; Beatty P; Gasarch L; Shaughnessey S. **Old answers for today's problems: integrating individuals who are homeless with mental illness into existing community-based programs. a case study of Fountain House.** Psychosocial Rehabilitation Journal, 18(1): 75-93, 1994.

Individuals who are homeless and mentally ill are continually underserved and neglected by state and local social service agencies. This article describes an urban vocational rehabilitation agency's implementation of an outreach project designed to provide employment and housing services to this group from June 1990 to May 1992. The 228 participants met diagnostic criteria for major mental illness, and 47% were employed during the project. Inter-agency linkages and essential components for such a model are listed. The results suggest that the needs of this population can be met if the consumers' wants take precedence over agency dictum.

Bolland JM; Wilson JV. **Three faces of integrative coordination: a model of interorganizational relations in community-based health and human services**. Health Serv Res 29:341-66, August 1994

OBJECTIVE: This study develops a theoretically justified, network-based model of integrative coordination in community-based health and human services, and it uses this model to measure and compare coordination in six elder service systems. DATA SOURCES AND STUDY SETTING: We collected data between 1989 and 1991 in six Alabama counties, including two major MSAs, two small MSAs, and two rural areas. STUDY DESIGN AND DATA COLLECTION/EXTRACTION METHODS: Our measurement of coordination is based on patterns of interorganizational relationships connecting the agencies constituting a community-based health and human services system. Within each site, we interviewed representatives from these agencies, asking them to indicate client referral, generalized support, and agenda-setting relationships they had developed with each of the other agencies in the system. Using network analysis procedures we then identified the network associated with each of these organizational functions (i.e., service delivery, administration, and planning) in each site, and we assessed levels of coordination in each network. PRINCIPAL FINDINGS: Our measure of integrative coordination is consistent with other indicators of coordination we derive from our data, suggesting its validity. In addition, levels of integrative coordination across sites for each organizational function are generally comparable. Comparisons across sites show integrative coordination to be consistently highest for service delivery networks and lowest for planning networks. CONCLUSIONS: Previous attempts to assess interorganizational coordination without regard to organizational function are subject to misinterpretation. The differing interorganizational dynamics involved in service delivery, administration, and planning appear to generate different patterns of interorganizational relationships, and different levels of coordination.

Bredesen P. **Public/private partnerships in managed care**. Journal of Health Care for the Poor and Underserved 5(3): 185-9; discussion 190-1, 1994.

Although public/private partnerships are often viewed as mechanisms for using private monies to finance public needs, partnerships among health care providers, the business and legal communities, and the public sector offer promise as a way to realign the provision of health care to special-needs communities in the present era of managed care. In Nashville, Tenn., such a partnership promises to provide efficient, state-of-the-art medical care through a centralized city-wide clinic for HIV- positive individuals.

Chueh HC; Barnett GO**. Client-server, distributed database strategies in a health-care record system for a homeless population.** J Am Med Inform Assoc,1(2):186-98, March-April 1994.

OBJECTIVE: To design and develop a computer-based health-care record system to address the needs of the patients and providers of a homeless population. DESIGN: A computer-based health-care record system being developed for Boston's Healthcare for the Homeless Program (BHCHP) uses client-server technology and distributed database strategies to provide a common medical record for this transient population. The differing information requirements of physicians, nurses, and social workers are specifically addressed in the graphic application interface to facilitate an integrated approach to health care. This computer-based record system is designed for remote and portable use to integrate smoothly into the daily practice of providers of care to the homeless. The system uses remote networking technology and regular phone lines to support multiple concurrent users at remote sites of care. RESULTS: A stand-alone, pilot system is in operation at the BHCHP medical respite unit. Information on 129 patient encounters from 37 unique sites has been entered. A full client-server system has been designed. Benchmarks show that while the relative performance of a communication link based upon a phone line is 0.07 to 0.15 that of a local area network, optimization permits adequate response. CONCLUSION: Medical records access in a transient population poses special problems. Use of client-server and distributed database strategies can provide a technical foundation that provides a secure, reliable, and accessible computer-based medical record in this environment.

Cwikel J. **Social epidemiology: an integrative research and practice strategy applied to homelessness.** Journal of Social Service Research, 19(1/2):23-47, 1994.

Social epidemiology provides social workers with methodological tools that can lead to informed treatment choices in dealing with complex social problems. This paper defines social epidemiology, delineates the types of research questions that can generate data applicable to social interventions, and briefly outlines some of the standard methods in use, using homelessness as an example. These methods include the development of empirically validated criteria, determining incidence and prevalence and identifying the appropriate samples for study. The use of relative risk ratios to quantify the importance of risk factors is suggested and demonstrated.

Devers KJ; Shortell SM; Gillies RR; Anderson DA; Mitchell JB; Erickson KL. **Implementing organized delivery systems: an integration scorecard**. Health Care Management Review,; 19(3): 7-20, Summer 1994.

Organized vertically integrated health systems are in a key position to play a major role in present health care reform efforts. To demonstrate a competitive advantage in the new health care environment, however, integration efforts must be successful. Based on a national study of nine organized delivery systems, this article develops measures of three types of integration that occur in vertically integrated health systems -- functional, physician-system, and clinical. These measures can be used as a scorecard to assess progress toward achieving integration objectives.

Interagency Council on the Homeless. **Priority: home! The federal plan to break the cycle of homelessness.** Washington, DC: U.S. Department of Housing and Urban Development, 1994.

In May of 1993 President Clinton signed an Executive Order directing the 17 federal agencies that make up the

Interagency Council on the Homeless (ICH) to prepare "a single coordinated Federal Plan for breaking the cycle of existing homelessness and for preventing future homelessness." A product of that effort, this document describes the changing nature of homelessness in the United States, briefly reviews the characteristics of the homeless population, and goes on to sketch the causes and outline the scale of the problem. It then turns to a concise history of programs mounted to assist homeless individuals and families in the 1980s. It evaluates those efforts and makes recommendations for new policies and programs to end homelessness. The authors contend that the ultimate answer to homelessness is also the answer to poverty. AVAILABLE FROM: Interagency Council on the Homeless, 451 Seventh Street, SW, Suite 7274, Washington, DC 20410, (202) 708-1480. (FREE)

Marzke C; Both D. **Getting started: planning a comprehensive services initiative.** New York, NY: National Center for Service Integration, 1994.

Many communities are beginning the process of changing their service delivery systems. The purpose of this resource brief is to help those initiating this process by summarizing some of the questions and issues that should be considered in the planning stages of a collaborative services reform effort, and by describing a set of documents that offer more in-depth guidance in thinking through these issues.

Packard G (ed.) **Integrated treatment of substance abuse and mental illness for homeless people with dual diagnoses**. Concord, NH: New Hampshire-Dartmouth Psychiatric Research Center, 1994.

The treatment of homeless people with co-occurring mental health and substance use disorders requires the integration of two treatment approaches which have traditionally been separate. In this manual the authors discuss their most recent approaches in the treatment of this population. Since 1987, the New Hampshire mental health system, under a grant from the Federal Center for Substance Abuse Treatment, has been using the assertive community treatment (ACT) model to provide treatment to dually diagnoses individuals. This approach has four distinct stages: (1) engagement; (2) persuasion; (3) active treatment; and (4) relapse prevention. Integrating the treatment of both types of disorders for delivery by ACT treatment teams and other forms of intensive case management is a relatively new, and still developing approach. This manual based on the author's experience with dually diagnosed homeless people in Connecticut, New Hampshire, Maine, and Washington, D.C.

1993

Center for Mental Health Services. **Services integration for homeless persons with severe mental illnesses.** Rockville, MD: CMHS, 1993.

This technical assistance report provides a general overview of services integration and answers specific questions designed to provide guidance for applicants for the federal ACCESS (Access to Community Care and Effective Services and Supports) program sponsored by the Center for Mental Health Services. After first defining services integration, the author briefly outlines the history of services integration in mental health policy, followed by some recent examples of services integration efforts. The principles of services integration are identified, and strategies for integrating services for homeless persons with severe mental illnesses are identified. The appendix includes an annotated bibliography on services

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Conrad DA. **Coordinating patient care services in regional health systems: the challenge of clinical integration**. Hospital Health Services Administration 38(4): 491-508, Winter 1993.

Regional health systems attempting to achieve the vertical integration of health services ultimately must achieve clinical integration. Vertical integration in health care involves the coordination of inputs (equipment, supplies, human resources, information, and technology) and intermediate outputs (preventive, diagnostic, acute; chronic,

and rehabilitative services) to attain the end goal of optimal personal health. Given this perspective, the coordination of specialty services and primary care within a system structure, that is, the clinical integration of patient care, is central to the realization of vertically integrated regional health systems. Institution-level and environmental factors that facilitate and challenge the attainment of clinical integration are elucidated, and a set of clinical integrating mechanisms are outlined with presentation of real-world examples of those mechanisms. The analysis concludes by summarizing the next steps in realizing this vision.

Lee H, Goodburn A. **Developing an integrated strategy to meet homeless families' health needs**. Health Visit, 66(2):51-53, February 1993.

Homeless families are vulnerable to considerable health problems, yet are overlooked in the government's national strategy for health. Access to services and contact with agencies are difficult for people displaced to a new area. The authors describe the health visiting service they offer homeless families in Camden, north London, where the majority are from outside the borough and many recent immigrants to this country.

Smith JR. **Creating an integrated health care delivery system: a regional nonprofit provider-case study**. Topics in Health Care Financing 20(2): 82-8, Winter 1993.

The development of integrated health care systems holds many pitfalls as well as potentials. This case study describes the development of the strategy that has moved the structure, mission, and vision of a health care system. It examines the questions of what members, payers, and providers' needs are when defined around the paradigm of responsibility for the health as well as the health care of a population. It starts by examining the background of the development of the strategies used by the health system during the past decade, and the environmental climate that has led to a redefinition of the mission and vision of the organization. This movement has moved the focus on acute health services to the development of a regional integrated health care system based on collaboration and on a responsibility to improve the health of those we serve through treatment, prevention, and education. Finally, the chapter reviews the options facing all of us: do we compete, collaborate, or both?
U.S. Dept. of Housing and Urban Development. **The D.C. initiative: working together to solve homelessness.** Washington, D.C., U.S. Department of Housing and Urban Development, 1993.

The D.C. Initiative, developed by HUD and the District of Columbia partnership, proposes to establish a "continuum of care" system in the District of Columbia, consisting of three basic components: outreach/assessment, transitional housing combined with rehabilitative services, and placement into permanent housing. This report describes the planned program to be implemented over two years. The current shelter system will be replaced with a system that distinguishes between the different subpopulations including adults with special needs, adults with short-term emergency shelter needs, families with special needs, families with short-term emergency shelter needs, and marginally housed families.

1992

Buckley R; Bigelow DA. **Brief report. The multi-service network: reaching the unserved multi-problem individual**. Community Mental Health Journal 28(1):43-50, 1992.

This paper describes an innovative collaboration among mental health, alcohol/drug treatment, corrections, forensic, and social and housing agencies to provide more effective services to multi-problem, service-resistant individuals at less cost. The theory is that interagency communication and external controls developed by core service agencies increase the efficacy of treatment and reduce the cost of caring for multi-problem clients.

Agencies refer clients to the Multi-Service Network who are then screened for problematic multi-agency involvement. Case conferences result in individual service plans. Three illustrative cases are described and the results of two evaluative studies summarized. Cost of care for clients appears to have been reduced.

Caplan PA; Lefkowitz B; Spector L. **Health care consortia: a mechanism for increasing access for the medically indigent**. Henry Ford Hospital Medical Journal 40(1-2): 50-5, 1992.

In response to poor coordination among health and social service providers, health care consortia have emerged in many areas of the United States. Consortia link multiple providers in a common structure to create comprehensive systems of care. They can be formally structured or informal combinations of providers that engage in coordination but otherwise do not comprise an independent organization. The functions most common among all types of consortia are shared services and service coordination; however, a number of consortia also operate outreach/education programs. Consortia represent an innovative response to the need both for vertical integration --case management of all levels of care--and horizontal integration to prevent duplication among primary care providers. We outline the history of consortia in which federally funded community health centers have participated. We also suggest an analytical framework for the various types of consortia; discuss lessons learned about building and maintaining consortia; and provide preliminary outcome data.

Carrillo JE; de Ia Cancela V. **The Cambridge Hospital Latino Health Clinic: a model for interagency integration of health services for Latinos at the provider level**. Journal of the National Medical Association 84(6): 513-9, June 1992.

Latinos who present for health services often suffer from a complex interaction of medical and mental health needs, requiring a multifaceted intervention. An essential element of this multilevel approach is cultural and linguistic sensitivity on the part of health providers. New, innovative models of health service organization are needed to address the unique needs of the Latino population. Some of the key characteristics these models need to focus on include interagency collaboration rather than competition for resources, interdisciplinary teams of primary care providers that also involve other non-medical professional members, centralized case coordination and decentralized service delivery, flexibility and adaptability to changing priorities, continuity of care for all patients, and mutual support among providers to minimize the effects of stress and burnout.

Dowell DA; Farmer G. **Community response to homelessness: social change and constraint in local intervention.** Journal of Community Psychology 20:72-83, 1992.

This report describes an action-research project that contributed to mobilizing a community to respond to homelessness in a large Southern California city. The project involved collaboration among a city-sponsored Task Force, a grass-roots coalition, and a university. The project core was a needs assessment which served as a basis for advocacy by the Task Force and a coalition of service providers and citizens. Empirical findings are reported along with political impacts including the ultimate fate of recommendations adopted by city government. An analysis of factors constraining policies relating to homelessness at the level of mid-size municipalities suggests that advocacy strategies must link local efforts with regional, state, and/or national levels to be effective.

Federal Task Force on Homelessness and Severe Mental Illness. **Outcasts on Main Street: report of the Federal Task Force on Homelessness and Severe Mental Illness**. Washington, DC: Interagency Council on the Homeless, 1992.

Representatives from all major federal departments whose policies and programs directly affect the homeless population with serious mental illnesses met over an 18-month period and issued this report to the Interagency Council on the Homeless. The authors present a plan of action that they believe reflects a vital first step toward

ending homelessness among people with serious mental illness. The report: (1) outlines fundamental principles and the essential components of an integrated and comprehensive system of care for homeless people with serious mental illness; (2) identifies immediate action steps and more long-term systemic measures that federal departments can take to facilitate state and local efforts; (3) proposes new opportunities for states and communities to develop, test, and improve the organization, financing, and delivery of a wide range of essential services for homeless people with severe mental illnesses; and (4) recommends steps that state and local organizations can take to respond more appropriately to the needs of homeless people with serious mental illnesses. AVAILABLE FROM: The National Resource Center on Homelessness and Mental Illness, 262 Delaware Avenue, Delmar, NY 12054, (800) 444-7415. (FREE)

Johnson AK; Banerjee, M. **Purchase of service contracts for the homeless: the development of a city-wide network.** The Journal of Applied Social Sciences 16(2):129-141, 1992.

A study of the development and implementation of the Homeless Services Network (HSN) in St. Louis, Mo., illustrates the issues confronting nonprofit agencies that contract with local government to provide services to disadvantaged populations, such as the homeless. This article depicts the complex patterns of cooperation and collaboration, as well as conflict and control, brought about by legally mandated, purchase of service (POS) agreements. The advantages and disadvantages for city government and different types of nonprofit, shelter agencies are discussed. The authors conclude that combining POS with a legal mandate for homeless services is a viable model for developing a city-wide, homeless service system.

Lewin-ICF. **Community models of coordination in primary care programs: final report.** Washington, DC: Department of Health and Human Services, 1992.

This report contains case studies of six communities noted for their efforts to integrate primary health care services among multiple organizations including Arlington, Va.; Hidalgo County, Texas; Albany, N.Y.; Miami, Fla.; Chicago, Ill.; and Seattle, W ash. The objective was to identify those factors within the communities that promote primary care service integration, the extent to which those factors are generalized across the communities, and their implications for future Health Resources and Services Administration (HRSA) programs and policies. The findings indicate that good communication, ongoing financial viability and efficient operations characterize successful and sustained service integration efforts. HRSA was also seen as important to the success of many of the integration efforts by providing funding and resources, and allowing providers to define their own systems of integration.

Morrow R; Halbach JL; Hopkins C; Wang C; Shortridge L. **A family practice model of health care for homeless people: collaboration with family nurse practitioners**. Fam Med, 24(4):312-316, May 1992.

The growth of a large population of people without permanent housing in the United States has brought with it the necessity to address the unmet health needs of this group. As homelessness spreads, its demographic pattern has become more heterogeneous, with young vulnerable families now the major subgroup. This paper explores issues of homelessness in Westchester County, N.Y., which, despite being the 10th richest county in the United States, has the highest per capita homeless rate in the state. Children younger than age 18 represent the majority of this group. Barriers to the delivery of health care services are described, including fragmented life-styles, lack of insurance, insensitivity of care givers, distance from services, and inflexibility of traditional sources of health care. A model that has been developed for delivery of services is discussed. This model, the Outreach Health Care Unit, is run by nurse practitioners in collaboration with family physicians and is centered at the site of social service activities for homeless families and single men in Yonkers, N.Y. It is a collaborative endeavor of a nursing school,

community hospital family practice residency program, and a network of social service agencies. The use of this model for education and research is also discussed since the goal is to provide both health services and training for health care providers.

1991

Bruner C. **Thinking collaboratively: ten questions and answers to help policy makers improve children's services. (1st, 2nd, and 3rd printing).** Washington, DC: Education and Human Services Consortium, 1991.

The author uses a question and answer format to help state and local policy makers consider how best to foster local collaboration between agencies. Checklists are provided to help policy makers quickly assess key issues in establishing interagency initiatives, demonstration projects, and statewide reforms to foster collaboration. While this report focuses on integrating services for children and families, the concept can be adapted to other efforts at collaboration.

Crane AB. **HRSA's collaborative efforts with national organizations to expand primary care for the medically underserved**. Public Health Reports 106(1): 104, January-February 1991.

As the Federal agency that provides leadership in expanding access to primary health care, the Health Resources and Services Administration (HRSA) manages some 50 programs directed toward the delivery of services and strengthening the base of national health resources. An enabling element of the agency's strategy is the expansion of partnerships with national associations, private foundations, and other entities that share a concern for the health care of the medically underserved. Cooperative efforts with national organizations are intended to promote the integration of public and private resources and encourage adoption of efficient approaches to organizing and financing health care. Medical education in the primary care specialties, State programs for women and children, involvement of managed care organizations with low-income populations, and programs concerning the uninsured are the foci of some of these collaborative relationships.

Gardner SL. **A commentary.** In Edelman PB; Radin BA, *Serving Children and Families Effectively: How the Past Can Help Chart the Future*. Washington, DC: Education and Human Services Consortium, 1991.

In this short piece, the author provides a set of nine general "lessons" to guide services integration efforts, along with some cautionary advice. Gardner's lessons emphasize that true services integration requires basic systems change, and cannot be accomplished through minor reorganizations and adjustments. Long-term planning, changes in program financing, increased accountability, and the commitment of talented leaders are all prerequisites to lasting effectiveness. Gardner also stresses the political nature of services integration; it is critical to build a strong constituency for change, both amongst local and state policy-makers and funders, and at the program staff level, where the new service delivery approaches are actually implemented.

Kline J; Harris M; Bebout R; Drake RE. **Contrasting integrated and linkage models of treatment for homeless, dually diagnosed adults.** In Minkoff K; Drake RE (eds.), *Dual Diagnosis of Major Mental Illness and Substance*

Disorders. New Directions For Mental Health Services 50: 95-107. San Francisco, CA: Jossey-Bass, 1991.

The authors describe two prominent models of treatment for homelessness and dual diagnosis that are commonly used by clinicians and program planners. The linkage treatment model provides a full range of clinical case management services to treat psychiatric disorders while pursuing a program of aggressive outreach and referral to community substance abuse resources. The model emphasizes the significance of social networks in the maintenance of addictive behavior and employs aggressive interventions to change the nature of client social networks. The integrated treatment model provides the full range of clinical case management services while also offering comprehensive substance abuse treatment in-house. This approach emphasizes intensive group work coordinated with individual counseling.

Mechanic, D. **Strategies for integrating public mental health services.** Hospital and Community Psychiatry 42(8):797-801, 1991.

This article describes four approaches to building a viable public mental health system: developing assertive community treatment systems (ACT); capitating mental health care; building strong local mental health authorities; and developing supportive reimbursement structures. The author then focuses on the importance of integrating these four approaches in a mutually reinforcing way.

1990

Johnson AK; Castengera AR. **Integrated program development: a model for meeting the complex needs of homeless persons**. Cleveland, OH: Case Western Reserve University, 1990.

This paper begins with a brief review of literature on the use and purpose of case management and group work practice with homeless persons. Based on information from a program evaluation at The Salvation Army Family Haven in St. Louis, Missouri, the authors illustrate how both case management and social group work are important components of comprehensive programming for homeless persons. The authors conclude by suggesting a framework for program development that integrates both of these intervention methodologies. This framework, Integrated Program Development (IPD), is adapted from the Integrated Practice framework, an advanced generalist practice model developed by Parsons, Hernandez, and Jorgensen.

Martin MA. **The homeless mentally ill and community-based care: changing a mindset.** Community Mental Health Journal 26(5):435-447, 1990.

The author presents a framework for developing a comprehensive system of care for homeless mentally ill persons that reconceptualizes clients, services, and the interactions between them. The history of community-based care for persons with long-term mental illness is reviewed and the functions of a Community Support System (CSS) model of services are outlined. A holistic approach, requiring the provision of a variety of health, mental health and social welfare programs is recommended to respond effectively to the needs of homeless mentally ill persons.

Pollio D. **The street person: an integrated service provision model.** Psychosocial Rehabilitation Journal 14(2): 57-68, 1990.

This article examines service provision to street persons and describes an integrated model that allows for consumer initiated participation. The range of services is explored, and concepts for developing a treatment

program are presented in the context of a philosophy of client empowerment.

1987

Homelessness Information Exchange. **Coalition building to address homelessness: guidelines/models/ accomplishments.** Washington, DC: Homelessness Information Exchange, 1987.

This manual contains a compilation of guidelines for developing community-wide coalitions and addresses the role of coalitions in assessing community needs and coordinating local efforts related to homelessness. It includes examples and accomplishments of local, public and private coalitions.

1985

Mauch D (ed). **Homelessness: an integrated approach**. Boston, MA: Massachusetts Association for Mental Health, 1985.

This report was written for policymakers and program providers to share the approach to homelessness taken in the Commonwealth of Massachusetts, which was designed to integrate agency efforts and resource application in response to the homelessness issue. The report contains background data on homelessness within the national context, characteristics of people who are homeless, a description of the methods and models used in the integrated approach, and recommendations for cooperative efforts as a solution to the problem of homelessness.

Undated

Cocozza JJ; Steadman HJ; Dennis DL; Blasinsky M; Randolph FL; Johnsen M; Goldman H. **Creating successful systems integration strategies: lessons from the ACCESS program for people who are homeless and mentally ill.** Delmar, NY: Policy Research Associates, undated. DRAFT.

In 1993, the Access to Community Care and Effective Services and Supports (ACCESS) federal demonstration program was initiated. Supported by the Center for Mental Health Services, it was a five-year demonstration program to assess the impact of integrated systems of care on outcomes for homeless persons with mental illness. Using a quasi-experimental design, each of the nine funded states selected had an integration and a control site. Here the authors examine which integration strategies were chosen and how to quantify their implementation. Data were collected through annual site visits, from relevant written documents, and semi-annual telephone calls with site staff. It was found that only two strategies were used by all nine systems, six by the majority of the sites, and others in three or four sites. The systems integration strategies employed remained relatively stable over the five years. The authors conclude that successful implementation appears to be dependent on the strategies

selected, since some strategies had a high probability of successful implementation that others.

Mullins SD. **Steps out: a peer-integrated outreach and treatment model for homeless persons with co-occurring disorders**. Rockville, MD: Substance Abuse and Mental Health Services Administration, undated.

This manual describes a peer-based treatment initiative designed to assist homeless individuals who suffer from both substance abuse disorders and co-occurring mental illness. The program's central philosophy is that outreach coordinated by staff who were once homeless is an effective means of linking program participants with prevocational and vocational opportunities. Topics discussed include a conceptual framework, history and setting of the intervention, review of the literature, description of participant population, description of the intervention, case studies, and lessons learned.

U.S. Department of Health and Human Services. **Strengthening homeless families: a coalition-building guide.** Washington, DC: HRSA, Administration for Children and Families, undated.

The purpose of this guide is to assist shelters and community-based agencies to plan, develop, and implement collaborative services designed to strengthen homeless families and create systematic change within the community. Chapter One provides a brief overview of the multiple needs of homeless families and children. It frames the rationale for a comprehensive, collaborative, community-based approach. Chapter Two discusses the strategic planning process-- the conceptual framework for coalition building-- and lays the foundation for the specific coalition-building issues and strategies. Chapter Three is a step-by-step implementation guide to collaboration among shelters and traditional and nontraditional allies. Also included are an appendix and references for further reading.

Vietnam Veterans of San Diego, Inc. **Vietnam Veterans of San Diego: integrated treatment for homeless veterans with co-occurring mental illnesses and substance use disorders**. Rockville, MD: Substance Abuse and Mental Health Services Administration, undated.

Vietnam Veterans of San Diego (VVSD) provides up to one year of intensive residential rehabilitation services to male and female homeless veterans who are dually diagnosed. About half of VVSD's residents are Vietnam veterans, 25% are parolees, and 10% are women veterans. Virtually all are substance-dependent, many suffer from Post-traumatic Stress Disorder (PTSD), and others have major depression or personality or anxiety disorders. The manual describes the residential program and elements essential to providing services. Their approach engages and retains a high proportion of homeless dually diagnosed veterans through to independent living. This treatment manual includes the following: conceptual framework; history and setting of the intervention; literature review; description of client population; description of the intervention; program structure; the treatment process; case studies; and lessons learned.